**Title:** Perinatal PCM at the USC School of Medicine: A Collaborative Formula that Works for Mothers and their Children.

**Organization:** SC Department of Health and Environmental Control (DHEC) – Grantee; University of South Carolina School of Medicine (USCSOM) - Contractor

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**Topical Issues of Focus:** Case management, using CDC funding to build on existing HIV programs, successful collaborations between programs to prevent perinatal HIV

## Background/Objectives

The overall goal of the *University of South Carolina School of Medicine Perinatal HIV Prevention Case Management Program* (USC PCM) is to ensure that pregnant HIV infected women and HIV exposed infants have access to appropriate prevention interventions to reduce perinatal HIV transmission, and that HIV infected women have access to appropriate treatment and prenatal care services. Intensive case management services are provided to pregnant HIV-positive women, many of whom experience complex psychosocial issues that increase the difficulty of adhering to recommended antepartum or postpartum therapy and/or care plans. Proposed objectives for 2003 include:

- 95% referred, infected pregnant women will receive perinatal prevention case managements services
- 95% of infected pregnant women will receive adequate prenatal care (as defined by MCH program)
- 95% of infected pregnant women that have chosen HIV therapy will keep their infectious disease appointments through beginning of PCM enrollment to term of pregnancy
- 100% of known HIV exposed infants, where medically appropriate, are started on their postpartum 6-week AZT prescription without any detrimental delay.
- 100% of infants will receive pediatric infectious disease specialty consult prior to hospital discharge
- 100% of infants/families will keep their first two Ryan White Title IV pediatric infectious disease clinic appoints, within medically optimal time frame

## Methods

Prevention and surveillance staff at DHEC worked together to decide which areas of the state were in greatest need of perinatal PCM based on prevalence and incidence rates of HIV exposed infants. Columbia (Richland County area), Sumter, and Charleston were identified. A contract was established with the USC School of Medicine to serve Columbia and Sumter. In June 2001, USC PCM began providing services to the Richland County area. Nancy Raley, MPH, Executive Director of the Midlands Care

Consortium, a SC Ryan White Title II contractor, established a Memorandum of Understanding with the USC SOM department of Obstetrics and Gynecology to provide space and logistical support in the Palmetto Richland Obstetrics Clinic for a full-time perinatal PCM to provide case management services both face-to-face and via telephone. This OB clinic is a well-established provider that serves a large population of women at risk for HIV infection, and receives most of its low income, high-risk pregnancy referrals from Richland County and eight surrounding counties. On "high-risk" clinic days the PCM representative is present at the clinic for the mother's prenatal appointments. The PCM representative delivers information, health education, counseling (to include posttest, adherence, risk reduction, and client-centered counseling), resource linkage, care coordination, and a wide variety of other psychosocial interventions based on need. The PCM representative also conducts home visits.

In addition to the formal partnership with the OB clinic, the program's success lies in it the way it fits within and builds upon the existing Ryan White Title II & Title IV care systems. The PCM serves as a bridge between different clinics such as OB, Adult Infectious Disease (ID), Pediatric Infectious Disease, the local health department, ASO adult case management services, and local CBO support services. Since the PCM representative is an employee of a Ryan White Title II consortium, she is a member of the team that delivers Adult ID and case management. Therefore, the PCM has access to many resources to help women living with HIV/AIDS. For example, existing resource mechanisms such as HOPWA, emergency financial assistance, and transportation assistance (gas vouchers, bus tickets, and taxi) are available for use by the PCM representative.

At the state department of health level, the project administrator of the SC Title IV Program is also the manager of the Perinatal PCM Program. Therefore, there is the formal expectation that the Title IV staff, including pediatric infectious disease staff and the PCM work together to ensure continuity of care occurs between outpatient OB, inpatient labor and delivery, hospital consultation, discharge, and admission to outpatient pediatric ID and the Title IV care system. The PCM representative utilizes a Title IV consumer advocate (African American women living with AIDS, with an infected child) to provide emotional support and information to pregnant women desiring to see a consumer advocate. The PCM administrator also coordinates with the Women's Resource Center, a Title II and Title IV partner that aims to support and empower women living with HIV, to give pregnant women an opportunity at non-clinic, private, individual, and group-level support from peers, many of whom have children.

Program success is assessed and documented through quantitative and qualitative data requested by CDC. Enrollment, demographic, output (services provided), and narrative is collected/provided by the PCM administrator and program manager. DHEC surveillance staff members collect EPS and HARS data for outcome measurement (surveillance data not yet available to match with the term of PCM program in Richland County). Collection of other outcome data by prevention staff members on proposed objectives A, C, E, and F is currently being considered.

**Results and Conclusions**

The practice is certainly meeting its process-based objectives, as evidenced by service outputs and qualitative data regarding varying case scenarios where pregnant women received much needed services and education. From June 2001–December 31, 2002 the USC PCM provided 250 face-to-face and 287 non face-to-face case management encounters for 62 clients (duplicated); 50+ (unduplicated). Presentation of successful cases is perhaps the best means demonstrating the program's major accomplishments. We know that our system is promoting adequate prenatal care and the keeping of OB and ID visits. We are especially excited about private obstetricians (non-teaching hospital OBs) wanting to utilize the PCM's services. We also know that the "system" of care is directly improved through the PCM's work, especially in the transition from hospital to outpatient pediatric ID care. It is now rare for inpatient pediatric ID consults, infant AZT therapy, and the keeping of initial pediatric ID appointments not to occur. Missed opportunities appear to be less likely to occur when the PCM administrator is a team member. Now, however, outcome-based data through HARS and EPS are not complete for analysis and usage in program evaluation.

Since the program is integrated into an existing, well supported, and organized care system it has had the capacity to be successful from day one. In trying to replicate the program in other areas it is noted that lacking a Memorandum of Understanding or other written agreement between departments of Internal Medicine and Obstetrics/ Gynecology leads to confusion and ineffectiveness (e.g., verbal agreements through Medical Directors is not enough---the PCM administrator needs space, access to basic patient information/referral sheets, and support from other staff in the practice). In addition, it's critical for the PCM administrator to see patients at their OB appointment, rather than ID. This kind of set-up is a proactive appointments way for the PCM administrator to have <u>many</u> more opportunities to serve patients face-to-face, rather than the less frequent ID.